MDR Tracking Number: M5-04-3411-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-7-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

One unit of CPT code 97035 and one unit of CPT code 97124, CPT code 97122, CPT code 98940 and CPT code G0283 from 7-16-03 through 7-30-03 and from 8-20-03 through 11-19-03 were found to be medically necessary. All units of 97032 and one unit of 97035 from 7-16-03 through 7-30-03 and from 8-20-03 through 11-19-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-8-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97032 on 7-15-03, 8-6-03 and 9-17-03 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

CPT code 99212 on 8-6-03 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

CPT code 97035 on 8-6-03 and 9-17-03 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

CPT code 97124 on 8-6-03 and 9-17-03 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

CPT code 97122 on 8-6-03 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

CPT code 97140 on 8-20-03, 8-22-04, 8-25-04, 8-27-04, 8-29-04, 9-03-3 and 9-17-03 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

CPT codes 98940 on 9-17-04 was denied with an "N" – Not appropriately documented. The requestor provided no additional documentation to support this service. **No reimbursement recommended.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 7-16-03 through 11-19-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 6th day of January, 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da
Enclosure: IRO decision

Amended Report

October 27, 2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-3411-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to the records received, the patient, ___, was injured in a work related automobile accident on ___ were the patient sustained injuries to his lumbosacral spine. ___ was working for ___ when he was injured. He presented to Dr. Stephenson for care and management of his injuries.

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of electrical stimulation, manual therapy techniques, massage (including effleurage, petrissage and/or tapotement), ultrasound, chiropractic manipulative treatment, spinal (one to two regions) and electrical stimulation

(unattended) from 7-16-2003 through 7-30-2003, 8-20-2003 through 11-19-2003 (excluded CPT codes 97140).

DECISION

In regards to dates of service 7-16-2003 through 7-30-2003 and 8-20-2003 through 11-19-2003.

The reviewer agrees with the previous adverse determination regarding all units of 97032 – electrical stimulation attended.

The reviewer disagrees with the previous adverse determination regarding 1 unit of 97035 on each date of service in question.

The reviewer agrees with the previous adverse determination regarding the second unit of 97035 on each date of service in question.

The reviewer disagrees with the previous adverse decision regarding 1 unit of 97124 on each date of service in question.

The reviewer disagrees with the previous adverse determination regarding 97122 for each date of service in question.

The reviewer disagrees with the previous adverse decision regarding 98940 and G0283 for each date of service in question.

BASIS FOR THE DECISION

The basis for the above determination is based upon Evidence Based Medical Guidelines, Medical Disability Advisor, Official Disability Guidelines and the Texas guidelines for Quality Assurance and Practice Parameters. Specifically the treatment time period in question falls within acceptable practice parameters regarding the dates of service under review for the injury. The dates of service fall within approximately 8 weeks of the date of injury.

Specifically to the treatment methods, according to the MDA in regards to manual traction "it is a common, effective treatment especially in injuries sustained during high-energy traumas such as motor vehicle accidents and falls." Ultrasound and massage are also widely acceptable treatment modalities for this type of injury according to the literature. However, one unit per body part / region is clinically necessary. The documentation does not support the need for additional units or time. In addition, although electrical stimulation is also a widely acceptable treatment modality for soft tissue injuries, the necessity of attended electrical stimulation is not established by the documentation and shows no benefit over unattended therapy.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has

made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO
CC: Specialty IRO Medical Director